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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **DENISE MARIE ORTIZ** 15315 W. Cortez Street Surprise, Arizona 85379 Registered Nurse License No. 625464 Respondent.	Case No. 2009-151 **ACCUSATION**

Ruth Ann Terry, M.P.H., R.N. ("Complainant") alleges:

PARTIES

1. Complainant brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing ("Board"), Department of Consumer Affairs.

Registered Nurse License

2. On or about September 4, 2003, the Board issued Registered Nurse License Number 625464 to Denise Marie Ortiz ("Respondent"). The registered nurse license expired on December 31, 2006.

STATUTORY PROVISIONS

3. Section 2750 of the Business and Professions Code ("Code") provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a

temporary or an inactive license, for any reason provided in Article 3 (commencing with Code section 2750) of the Nursing Practice Act.

4. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under Code section 2811, subdivision (b), the Board may renew an expired license at any time within eight years after the expiration.

5. Code section 2761 states, in pertinent part:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct, which includes, but is not limited to, the following:
>
> (4) Denial of licensure, revocation, suspension, restriction, or any other disciplinary action against a health care professional license or certificate by another state or territory of the United States, by any other government agency, or by another California health care professional licensing board. A certified copy of the decision or judgment shall be conclusive evidence of that action.

6. Code section 2762 states, in pertinent part:

> In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:
>
> (a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.

7. Code section 4060 states, in pertinent part:

> No person shall possess any controlled substances, except that furnished to a person upon the prescription of a physician, dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor....

8. Health and Safety Code section 11173, subdivision (a) provides that no person shall obtain or attempt to obtain controlled substances, or procure or attempt to procure the administration of or prescription for controlled substances, (1) by fraud, deceit, misrepresentation, or subterfuge; or (2) by the concealment of a material fact.

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COST RECOVERY

9. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

10. **DRUGS**

"Hydromorphone", also known as "Dilaudid", is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivisions (b)(1)(K), and a dangerous drug under Code section 4022 in that under federal or state law it requires a prescription.

"Morphine" is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(M), and a dangerous drug under Code section 4022 in that under federal or state law it requires a prescription.

FIRST CAUSE FOR DISCIPLINE

(Out-of-State Discipline)

11. Respondent's license is subject to disciplinary action under Code section 2761, subdivision (a)(4), on the grounds of unprofessional conduct, in that Respondent has been disciplined by The Arizona State Board of Nursing (hereafter "Arizona Board"). Effective August 28, 2008, pursuant to the Consent for Entry of Voluntary Surrender Order No. 0701026 filed by the Arizona Board, attached hereto as **Exhibit "A"** and incorporated herein, Respondent voluntarily surrendered her Arizona Professional Nurse License Number RN134601. The basis for discipline was that on or about January 4, 2007, Respondent self-reported to the Arizona Board that she had been terminated from her employment at Banner Estella Hospital for failing to document administration or wastage of numerous doses of the controlled substances hydromorphone and morphine, which Respondent removed from the Pyxis system. Further, on or about June 6, 2008, Respondent was taken to Del Webb Emergency Room after being found unconscious and not breathing in her home, surrounded by nine empty vials of the controlled substance morphine. None of the vials contained any prescription information.

SECOND CAUSE FOR DISCIPLINE

(Obtained and Possessed Controlled Substances in Violation of Law, and Self Administration)

12. Respondent's license is subject to discipline under Code section 2762, subdivision (a), on the grounds of unprofessional conduct, in that from approximately October 1, 2006, to December 26, 2006, while on duty as a registered nurse at Banner Estella Hospital, Phoenix, Arizona, Respondent committed the following acts:

a. Respondent obtained the controlled substances hydromorphone and morphine by fraud, deceit, misrepresentation or subterfuge, by taking the drugs from hospital supplies for her own use, in violation of Health and Safety Code section 11173, subdivision (a).

b. Respondent possessed the controlled substances hydromorphone and morphine in violation of Code section 4060.

c. Respondent self-administered unknown quantities of the controlled substances hydromorphone and morphine without lawful authority.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 625464, issued to Denise Marie Ortiz;

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2. Ordering Denise Marie Ortiz to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Code section 125.3; and,

3. Taking such other and further action as deemed necessary and proper.

DATED: 1/6/09

RUTH ANN TERRY, M.P.H., R.N.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

03579110-SA2008305712
Ortiz.Acc
ps (11/18/08)

EXHIBIT A

ARIZONA STATE BOARD OF NURSING
4747 North 7th Street, Suite 200
Phoenix, Arizona 85014-3653
602-889-5150

IN THE MATTER OF PROFESSIONAL NURSE LICENSE NO. RN134601 ISSUED TO: **DENISE MARIE ORTIZ,** Respondent.	**CONSENT FOR ENTRY OF VOLUNTARY SURRENDER ORDER NO. 0701026**

A complaint charging Denise Marie Ortiz ("Respondent") with violation of the Nurse Practice Act has been received by the Arizona State Board of Nursing ("Board"). In the interest of a prompt and speedy settlement of the above-captioned matter, consistent with the public interest, statutory requirements, and the responsibilities of the Board, and pursuant to A.R.S. §2-1663 (D)(5), Respondent voluntarily surrenders her license for a minimum of three years.

Based on the evidence before it, the Board makes the following Findings of Fact, Conclusions of Law:

FINDINGS OF FACT

1. The Arizona State Board of Nursing ("Board") has the authority to regulate and control the practice of nursing in the State of Arizona, pursuant to A.R.S. §§32-1606, 32-1646, 32-1663, 32-1664, 41-1064 (C), 41-1092.11(B), and 41-1092.07(F)(5). The Board also has the authority to impose disciplinary sanctions against the holders of nursing licenses for violations of the Nurse Practice Act, A.R.S. §§32-1601 to -1667.

2. Respondent holds Board issued professional nurse license number RN134601 in the State of Arizona.

3. On or about January 4, 2007, the Board received a complaint/self-report from Respondent reporting that she had been terminated from Banner Estrella Hospital for failure to document medication administered to patients that she had removed from the PYXIS.

4. Respondent was employed at Banner Estrella Medical Center in Phoenix, Arizona from on or about August 20, 2006 through January 4, 2007.

5. On or about December 25, 2006, staff at Banner Estrella found medication discrepancies in some of Respondent's patients. The hospital initiated an audit of Respondent's medication administration from October 1, 2006 through December 26, 2006 and found the following:

a. According to medical record number 95614, on or about October 1, 2006, Respondent documented giving a dose of morphine a half an hour before it was removed from the PYXIS.

b. According to medical record number 98439, on or about October 20, 2006, Respondent removed a dose of morphine 2mg IV from the PYXIS for a patient who was not assigned to Respondent. She did not document this dose as given or wasted.

c. According to medical record number 98477, on or about October 21, 2006, Respondent documented giving a dose of hydromorphone 2mg IV to a patient, but the medication was not removed from the PYXIS until three hours later; one hour after the patient was discharged.

d. According to medical record number 96024, on or about October 21, 2006, Respondent removed a dose of hydromorphone 2mg IV from the PYXIS. Respondent did not document giving the dose or assessing the patient.

e. According to medical record number 99057, on or about October 26, 2006, Respondent removed a dose of morphine 4mg IV from the PYXIS and did not account for 1mg of the

morphine in her documentation. Respondent withdrew another 2mg of morphine from the PYXIS fifteen minutes later and documented giving it to the patient.

f. According to medical record number 100242, on or about November 2, 2006, Respondent removed a dose of morphine 2mg IV from the PYXIS for a patient who was not assigned to Respondent. Respondent did not document this dose as given or wasted.

g. According to medical record number 62432, on or about November 12, 2006, Respondent removed a dose of hydromorphone 2mg IV from the PYXIS. Respondent did not document this dose as given or wasted.

h. According to medical record number 40283, on or about November 24, 2006, Respondent removed a dose of morphine 4mg IV from the PYXIS. Respondent documented administering 2mg but did not account for the other 2mg. Respondent charted administering the medication thirty-five minutes before removing it from the PYXIS.

i. According to medical record number 33832, on or about December 4, 2006, Respondent removed a dose of morphine 4mg IV from the PYXIS. The patient was not assigned to Respondent, and she did not document this dose as given or wasted.

j. According to medical record number 18247, on or about December 5, 2006, Respondent removed two doses of hydromorphone 2mg IV from the PYXIS within six minutes. Respondent wasted 1mg, documented giving 1mg but did not account for the other 2mg.

k. According to medical record number 33259, on or about December 7, 2006, Respondent removed a dose of hydromorphone 2mg IV from the PYXIS. Respondent withdrew this dose without documentation. Four minutes after the previous dose was withdrawn, Respondent withdrew another 2mg of hydromorphone and wasted 1mg. Respondent properly documented the 1mg dose. The order was for 1mg of hydromorphone to be given once.

l. According to medical record number 14215, on or about December 10, 2006, Respondent removed a dose of hydromorphone 2mg IV from the PYXIS and wasted 1mg. Nine minutes later Respondent withdrew another 2mg of hydromorphone from the PYXIS and wasted 1mg. The second dose was not documented. The order was for hydromorphone 1mg to be given once.

m. According to medical record number 68588, on or about December 13, 2006, Respondent removed a dose of morphine 4mg IV from the PYXIS. Respondent documented giving this dose twenty minutes before it was withdrawn.

n. According to medical record number 40671, on or about December 21, 2006, Respondent twice removed a dose of hydromorphone 1mg IV before it was ordered and failed to account for 1mg of the dose. Respondent withdrew another dose of hydromorphone 1mg IV that was not ordered and was not documented or wasted.

o. According to medical record number 100451, on or about December 26, 2006, Respondent removed a dose of hydromorphone 2mg IV from the PYXIS. The patient was not assigned to Respondent and the medication was documented by another nurse.

6. Respondent was terminated from Banner Estrella Hospital on or about January 4, 2007 for failure to document medication administered to patients after removal from the PYXIS.

7. From on or about July 30, 2007 through the present, Respondent has been employed at Hospice of the Valley in Phoenix, Arizona.

8. On or about May 1, 2008, the Board received a complaint from Hospice of the Valley alleging that Respondent exhibited unusual behavior during her shift on or about April 14, 2008.

9. On or about April 18, 2008, Respondent received a written warning for the following events that occurred on or about April 14, 2008:

a. Respondent wrote in W.D.'s patient record, "Will wait until morning to call family and just fill them in on her decline and disease process advancing fencing...loved SVN tx and decreased level for . Also got bit by a rattle snake into your neck. Face. Has face. Report given to day nurse."

b. In a taped patient report, Respondent's speech is slurred and at times unintelligible. At one point, Respondent states, "she moves pretty good, I has a softball tryout yesterday...my Team Leader asked me to be on her team so I said 'sure why not' so hopefully that is where I will be transferring. So that is about it, she got about two breakthroughs..."

c. A doctor and the Team Leader observed and noted Respondent had slurred speech, unsteady gait, and when standing still was swaying back and forth. Respondent's arm movements were also slow.

d. Despite Respondent's shift ending at 7:30 am, Respondent did not complete the charts on her four patients until 9:15 am.

10. Hospice of the Valley requested Respondent go for a for-cause urine drug screen on or about April 14, 2008. Respondent tested positive for amphetamines, oxazepam, nordiazepam, temazepam and morphine. Respondent had a prescription for all of these medications and therefore the urine drug screen was negative.

11. On or about June 6, 2008, a complaint was received by the Board reporting that Respondent was brought to Del Webb Emergency Room after being found unconscious and not breathing at home. Respondent was found with nine empty vials of morphine around her with no prescription information. Respondent also had noticeable track marks.

12. According to the medical records of Del Webb Hospital, on or about June 3, 2008, Respondent was brought to the Emergency Room in an ambulance. Respondent told the emergency

room staff that she had placed an IV in herself at home and had given herself a morphine IV due to stomach pain. Respondent admitted to a history of depression and bipolar disorder as well as undergoing electroconvulsive therapy in the past. The record states Respondent had three previous suicide attempts. Respondent was transferred to St. Luke's Behavioral Health on or about June 4, 2008.

13. On or about June 23, 2008, during a conversation with Board staff, Respondent stated her medication discrepancies at Banner Estrella were documentation only and denied that she had diverted narcotics for her own use. Respondent had difficulty remembering her hospitalization and had to ask another person in the room if this had occurred. She told Board staff that she had overdosed on her prescriptions for Hydromorphone and Percocet, not morphine. Respondent also told Board staff that she was currently receiving electroconvulsive therapy three times a week. She reported that she was being admitted to St. Luke's Hospital that day for inpatient treatment but did not know for how long.

14. Public health, safety and welfare imperatively require emergency action.

15. On or about July 28, 2008, Respondent requested to voluntary surrender her license.

CONCLUSIONS OF LAW

Pursuant to A.R.S. §§ 32-1606, 32-1663, and 32-1664, the Board has subject matter and personal jurisdiction in this matter.

The conduct and circumstances described in the Findings of Fact constitute a violation of A.R.S. § 32-1663(d) as defined in A.R.S. § 32-1601(16) (d) and (j) and A.A.C. R4-19-403(25) (a) (31) (adopted effective November 13, 2005).

The conduct and circumstances described in the Findings of Fact constitute sufficient cause pursuant to A.R.S. §§ 32-1663(D)(5) 32-1664(N) to take disciplinary action against Respondent's

license to practice as a professional nurse in the State of Arizona.

Respondent admits the Board's Findings of Fact, Conclusions of Law.

Respondent understands that she has an opportunity to request a hearing and declines to do so. Respondent agrees to issuance of the attached Order and waives all rights to a hearing, rehearing, appeal, or judicial review relating to this Order.

Respondent understands that all investigative materials prepared or received by the Board concerning these violations and all notices and pleadings relating thereto may be retained in the Board's file concerning this matter.

Respondent understands that the admissions in the Findings of Fact are conclusive evidence of a violation of the Nurse Practice Act and may be used for purposes of determining sanctions in any future disciplinary matter.

Respondent understands the right to consult legal counsel prior to entering into the Consent Agreement and such consultation has either been obtained or is waived.

Respondent understands that this voluntary surrender is effective upon its acceptance by the Executive Director or the Board and by Respondent as evidenced by the respective signatures thereto. Respondent's signature obtained via facsimile shall have the same effect as an original signature. Once signed by the Respondent, the agreement cannot be withdrawn without the Executive Director or the Board's approval or by stipulation between the Respondent and the Executive Director or the Board. The effective date of this Order is the date the Voluntary Surrender is signed by the Executive Director or the Board and by Respondent. If the Voluntary Surrender is signed on a different date, the later date is the effective date.

Respondent understands that Voluntary Surrender constitutes disciplinary action. Respondent also understands that she may not reapply for reinstatement during the period of Voluntary Surrender.

Respondent agrees that she may apply for reinstatement after the period of voluntary surrender under the following conditions, and must comply with current law at the time of their application for reinstatement:

The application for reinstatement must be in writing and shall contain therein or have attached thereto substantial evidence that the basis for the voluntary surrender has been removed and that the reinstatement of the license does not constitute a threat to the public's health, safety and welfare. The Board may require physical, psychological, or psychiatric evaluations, reports and affidavits regarding the Respondent as it deems necessary. These conditions shall be met before the application for reinstatement is considered.

Denise Marie Ortiz

Denise Marie Ortiz

Date: Aug. 20th 2008

ARIZONA STATE BOARD OF NURSING

SEAL

Joey Ridenour

Joey Ridenour, R.N., M.N., F.A.A.N.
Executive Director

Dated: 8/28/08

Barber/RN134601

ORDER

Pursuant to A.R.S. § 32-1663 (D)(5) the Board hereby accepts the Voluntary Surrender of professional nurse license number RN134601, issued to Denise Marie Ortiz. This Order of Voluntary Surrender hereby entered shall be filed with the Board and shall be made public upon the effective date of this Consent Agreement. Respondent shall not practice in Arizona under the privilege of a

multistate license.

IT IS FURTHER ORDERED that Respondent may apply for reinstatement of said license after a period of three years.

ARIZONA STATE BOARD OF NURSING

SEAL

Joey Ridenour, R.N., M.N., F.A.A.N.
Executive Director

Dated: 8/28/08

COPY mailed this 29th day of July, 2008, by First Class Mail to:

Denise Marie Ortiz
15148 W Pershing St
Surprise AZ 85379

By: Vicky Driver